Bölüm 11

SERVİKS KANSERİNDE EPİDEMİYOLOJİ RİSK FAKTÖRLERİ VE KLİNİK

Gülcan KOCAOĞLU[1]

GİRİŞ

Serviks kanseri dünya çapında en sık ölüme yol açan kanserler arasında üçüncü sırada yer almaktadır (Siegel& ark. 2018).Uterin korpus kanserleri ve ovaryen kanserlere oranla, gelişmişülkelerde, daha azmortalite insidansına sahiptir(Torre & ark. 2012). Ancakhenüzserviks kanseri tarama programı bulunmayan ülkelerde halen kanser nedenli ölümlerde 9.8/ 100000 oranıyla ve ensıkgörülen kanserlerde 17.8/ 100000 oranıyla ikinci sırayı almaktadır.

Servikal kanserlerin %99.7'sinden ve servikal intraepitelyal neoplazilerin gelişiminden human papillomavirus (HPV) sorumlu tutulmaktadır(Walboomers&ark. 1999). En sık görülen serviks kanseri histopatolojisi %69 ile yassı hücreli karsinom ve %25 ile adenokarsinomdur(Ries&ark.2007).

EPİDEMİYOLOJİ VE RİSK FAKTÖRLERİ

Tümdünyadaki insidansı ve mortalitesi, prekanseröz lezyonların ve HPV enfeksiyonunun tarama programlarıyla tanı alması ve tedavi edilmesi ayrıca HPV aşısının yaygınlaşmasısebebiyle gelişmiş ülkelerde başta olmak üzere azalmaktadır. Gelişmiş ülkelerde son 50 yılın verileriyle karşılaştırıldığında servikalkanserin mortalitesinde ve insidansında %75'e yakın bir azalma gözlenmektedir(Quinn&ark. 1999,Willoughby &ark. 2006). Servikal kanser vakalarının %84 kadarı az gelişmiş bölgelerden çıkmaktadır(Torre & ark. 2012).

YAŞ

Amerika'daki kadınlarda yaşamboyu serviks kanseri gelişme riski 20002004 yılları arasında %0.76 olarak hesaplanmıştır ve serviks kanseri ortalama tanı yaşı 48'dir(4). 20 yaş altındaki kızlarda 0.1/100000 20-24 yaş arasında 1.5/100000, 30-85 yaş arasında 11.0-15.8/100000 ve 85 yaş< vakaların %5.7si serviks kanseritanı almaktadır.

[1] Kadın Hastalıkları ve Doğum Uzmanı, Şanlıurfa Eğitim ve Araştırma Hastanesi, gulcankocaoglu@gmail.com

Serviks kanser taramasında servikalsitoloji testi ve HPV testi kombinekullanılmaktadır. Malinite semptomları olan ya da gözle görülebilen tümörü olan kadınlarda kullanılmamaktadır.

Servikal biyopsi ve kolposkopi

Servikal biyopsi malignite düşünülen hastalarda başlangıçta yapılanişlemdir. Hastanın pelvik muayenesinin ardından şüpheli bölgeden biyopsi alınmalıdır.

Gözle görülebilen lezyon varlığında, kanser tanısı şüphesini doğrulamak adına lezyonda biyopsi alınmalıdır. Biyopsi, en şüpheli görünen alandan alınmalı, nekrotik alandan mümkün oldukça alınmamalıdır. Serviks normalden gergin ya da büyükse punch biyopsialınmalı ve endoservikal küretaj yapılmalıdır. Bu durumlarda servikal sitolojinin değeri yoktur. Biyopsi sonrası meydana gelen kanmalarda Monsel solüsyonu kullanılabilir.

Gözle görülen lezyonu olmayan kadınlarda (semptomatik anormal servikal sitoloji) kolposkopi eşliğinde biyopsi alınmalıdır.

Semptomatik ancak gözle görülen lezyonu olmayan kadınlarda anormal sitoloji varlığında kolposkopi alında direkt servikal biyopsi alınmalıdır. Kolposkopide skuamokolumnar bileşke ve lezyon gözlenmeli bu bölgelerden biyopsi alınmalıdır. Kolposkopi imkanıyoksa direkt biyopsi alınabilir ya da VIM (visual inspection methods)ile alınabilir.

Maliniteden şüphelenildi ancak direkt servikal biyopside bulunamadı ve servikalkonizasyon gerekli ise(HGSILhigh grade cervical intraepithelial neoplasiaendoservikal küretaj pozitif displasziler), konizasyon mikroinvaziv kanserleri tanımada ve konservatif tedavisinde ya da radikal cerrahi öncesinde yolgösterici olarak kullanılabilen bir metottur.

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